



**AMERICAN COLLEGE
OF RHEUMATOLOGY**
EDUCATION • TREATMENT • RESEARCH

Specialists in Arthritis Care & Research

2200 Lake Boulevard NE • Atlanta, GA 30319-5312

Phone: (404) 633-3777 • Fax: (404) 633-1870

www.rheumatology.org • info@rheumatology.org

July 16, 2014

The Honorable Joseph Pitts
U.S. House of Representatives
Chairman, Energy and Commerce Subcommittee on Health
2125 Rayburn House Office Building
Washington, DC 20515

RE: Response to Questions for the Record, Committee on Energy and Commerce, Subcommittee on Health; Hearing Held June 12, 2014

Dear Chairman Pitts,

Thank you for the opportunity to appear before the Subcommittee on Health to testify at the hearing entitled "The President's Health Care Law Does Not Equal Health Care Access." Attached, please find my responses to additional questions that were submitted for the record after the hearing.

Please do not hesitate to contact me or the American College of Rheumatology should you have any follow-up inquiries. Thank you for the chance to provide these additional responses.

Sincerely,

William F. Harvey, MD, MSc
Chair, Government Affairs Committee
American College of Rheumatology

Attachment 1 – Additional Questions for the Record

The Honorable Renee Ellmers

Everyone knows that we are facing a shortage of primary care doctors, but many do not realize that the shortage extends to cognitive providers like rheumatologists and neurologists. It is my understanding that Obamacare provides a bonus to primary care providers but fails to include other physicians that bill the identical evaluation and management codes. This impacts really sick patients, those with severe arthritis or even diseases like MS. How is that impacting the recruitment of cognitive physicians to specialties like yours?

The country is indeed facing a shortage of many kinds of doctors. My fellow witness Dr. Gottlieb made a comment in response to a question indicating he did not foresee shortages of physicians. I strongly disagree with that statement. This was a trend existing before the Affordable Care Act (ACA) due primarily to the aging of the baby-boomer generation of Americans who have increasing health needs combined with an aging physician population who are nearing retirement. In my view this has been accelerated by the ACA due to people with newly acquired coverage entering the healthcare system over a relatively short time period. Where I practice in Massachusetts, we have had a coverage mandate for several years and what we have seen with increasing frequency are primary care doctors who are not taking new patients. Emergency rooms and urgent care clinics are overwhelmed by patients who cannot get to see their primary care doctor in a timely manner for urgent issues. Patients needing appointments with specialists are seeing increasing wait times even in a place like Boston where there are more doctors per capita than anywhere in the country. These shortages therefore not only affect those seeking urgent or primary care, but also the sickest patients requiring complex care by specialist physicians.

The Affordable Care Act, as well as other historical initiatives, has sought to address this problem by providing additional payments to providers in primary care. Another approach has been to structure new payment models around a primary care practice (i.e. ACOs and PCHM). Both of these strategies rely on defining which practitioners are eligible for that bump, or to lead these medical homes and in virtually every instance, that eligibility has been based on being board certified in family medicine, internal medicine or pediatrics. This is done on an inaccurate assumption that primary care doctors are the ones principally providing the primary care and care coordination that patients need and that help control costs. A major problem arises however when you consider that many patients with complex medical conditions receive the majority of their care from a provider traditionally designated as a specialist.

Here is a stark example. I have a panel of patients with rheumatoid arthritis or lupus. They see me 4 or 6 (or more) times a year for management of their disease. I screen their cholesterol, measure their blood pressure, send them to a cardiologist if they need it, coordinate their rehabilitation, etc. They see their primary care doctor less often. Their primary care provider and I bill the same evaluation and management code in the fee-for-service system for an office visit, yet for the same billing level, their primary care doctor is

paid 10% more than I am because they are a primary care doctor and I am a specialist. Under the PCMH model, the primary care doctor is receiving a large sum to coordinate care, yet the specialist is the one providing those services.

The fact is that rheumatologists, infections disease specialists, endocrinologists and neurologists, to name a few specialists, are the principal care providers and care coordinators for many of their patients with rheumatoid arthritis, HIV, diabetes and Multiple sclerosis. All of these providers, as well as primary care doctors, are facing critical shortages. Therefore differential reimbursement aimed at reducing physician shortages needs more parity. The ACR and a coalition of other cognitive specialists, including endocrinology, infectious diseases and neurology advocate for an alternate methodology. If the goal of incentive payments to certain doctors is to fairly reimburse them for invaluable services as well as to encourage entry into their fields of practice, then recipients of any bonus should be defined solely on the basis of what services they are providing rather than the type of doctor they are. That simple shift in philosophy, paying people for what they do, rather than what they call themselves, will introduce this needed parity.

The differential reimbursements have a major impact on recruitment. New physicians will always make a choice about what type of medicine they practice after considering what field they are passionate about. But in an era of increasing student debt and decreasing reimbursements, financial considerations are intruding on that decision more and more. This is at the expense of patients who need doctors of all types to care for them. Congress can take a major step in this regard by a) adequately valuing evaluation and management services in general and b) creating parity within bonus programs designed to incentivize areas of medicine with practitioner shortages by determining eligible providers based on services provided, rather than specialty designation.

Attachment 2 – Member Requests for the Record

The Honorable Gene Green

Would you provide the committee with some specific changes or reforms you would recommend making to the ACA to improve the law?

I view health care reform in this country as a living organism; an evolving creature with constant need for feeding, maintenance, evaluation and modification. The Affordable Care Act represents the largest body of aggregate reforms to our system in decades. Incumbent in the evolving nature of health care is the ability to adapt the system to new understandings and new challenges. I appreciate the opportunity to enumerate some for you.

In preface to those comments, I would emphasize the principal point that patients need access to health care. The doorway to access has at least three pillars, which include access to providers, access to treatments, and access to coverage for services. In my view, unless all three are adequately addressed, access will be incomplete. During the hearing, there was significant debate about the impact of the ACA on various definitions of access, mostly around these three facets. Put another way, a patient needs to see their doctor, their doctor needs treatments to offer, and the patient or the system needs to be able to pay for both.

Patient Access to Care

Repeal the Independent Payment Advisory Board – While the ACR understands the expanding costs of health care and that steps must be taken to control those costs, we do not believe that the IPAB as created in the ACA is the correct solution. Neither Congress, providers, nor patients would have adequate oversight of this body. Well-intentioned policies enacted to control costs often have unintended consequences. These are often first felt by patients and their doctors, and without adequate oversight the IPAB may bring harm to patients. The ACR believes that patients and their doctors should be the primary driver of medical decision making with other safeguards to help control costs.

Repeal the Sustainable Growth Rate payment formula – Though not included in the ACA, the ongoing issues and uncertainty surrounding the sustainable growth rate formula is driving physicians away from seeing Medicare patients, thus limiting access. We encourage Congress to pass a permanent, bicameral, bipartisan repeal of the SGR.

Tort reform – The practice of defensive medicine results in increased cost to the system in a myriad of ways, including unnecessary or duplicative testing. The ACR believes Congress should pursue meaningful tort reform that respects the right of patients to recover damages while protecting well intentioned and competent physicians. These reforms may include caps on non-economic damages, standards for expert witnesses, rigid statutes of limitation, limitations on contingency fees, elimination of joint and several liability, and creating alternative means of dispute resolution.

Extend and expand the Primary Care ‘bump’ – Due to the increasing physician shortage in this country, primary care providers, who provide coordination of care and evaluation and

management services to their patients, are afforded a bonus payment within the ACA. These providers include family medicine, internal medicine and pediatrics. This was done in part to address the shortages of primary care doctors by increasing their reimbursement. Many other specialists however provide the principal care of their patients and coordinate their care – typically, for patients with complex medical conditions. Examples include rheumatologists for patients with rheumatoid arthritis, infectious disease specialists for patients with HIV and neurologists for patients with multiple sclerosis. Each of these specialties also faces critical workforce shortages. The ACR strongly supports realignment of payment differentials on the basis of services provided (evaluation and management and care coordination vs. procedures) regardless of their specialty designation.

Prohibit overly restrictive provider networks – The ACR understands that both the federal government and the private payment sectors will need to look for innovative solutions to control costs. However, overly restrictive provider networks, intended to control costs, are restricting access to care. These include some geographic restrictions on crossing state lines for care, even when services are cheaper and closer in a neighboring state. They also include changing of provider networks after open enrollment periods end. Informed consumers shopping in the marketplace should be able to tell if the doctor they wish to see is included in that payer's network for the entire year until the next open enrollment. The restrictive provider networks also create an access problem in which they do not include adequate numbers of certain types of physicians within a payer network.

Patient Access to Treatment

Prohibit overly restrictive drug formularies – Again, the ACR understands the need to control costs; however formulary restrictions are resulting in restricted access to treatment. Additionally, payers should be restricted from changing drug formularies outside of open enrollment periods. Informed consumers shopping in the marketplace should be able to tell if the medication they may need is included in that payer's formulary for the entire year until the next open enrollment.

Prohibit excessive cost sharing – As noted in my testimony, an increasingly common practice for payers is to charge co-insurance for specialty drugs often at 30-40% or several thousand dollars per month. This practice existed before the ACA but has accelerated in the marketplaces. Charging vulnerable patients excessive co-pays is an unnecessary step. Data shows tiny premium increases, \$3 per beneficiary across a plan, would obviate the need for this practice, and restore access to treatments for patients with rheumatoid arthritis, multiple sclerosis, HIV, hemophilia, among many other chronic, disabling, and life-threatening diseases. Enacting HR 460, the Patient Access to Treatment Act would accomplish this.

Address the rising costs of prescription medications – The ACR, through its Rheumatology Research Foundation is the primary non-profit funder of arthritis research after the NIH. We understand very well the expense associated with research and development. The funding distributed by ACR pales in comparison to that expended by industry to support its research and development. The pharmaceutical and device industries are for-profit and fairly deserve to derive that profit by charging for their treatments. It is undeniable however that the rising costs associated with this research and development places a greater burden on the healthcare system and on patients who struggle to pay for the cost-sharing of their treatments. Meaningful

discourse and reform must take place to reduce the cost of medications, and this could include modifications to discount and negotiating programs, and reforms to the drug and device approval process that balance patient safety with cost of bringing a device to market.

Drug shortages – several key drug shortages have impacted the care of patients in this country. The ACR supports providing the FDA with the tools necessary to minimize drug shortages, including creating redundancies in drug supply chains and robust monitoring of drug production levels for key therapeutics.

Medicare reform – There are significant problems with Medicaid and Medicare beyond those listed above. These include adequate reimbursement for Part B drugs infused in an office setting. It also includes adequate reimbursement for preventative services. For example, bone density testing is now reimbursed at a level below the cost of purchasing, maintaining and operating the machine. Reduced access to testing results in more osteoporotic fractures in the elderly and more cost to the system by having the testing done only in hospital settings. Reimbursement was addressed in the ACA, but the provision expired in 2011 and should be renewed.

Dr. Gottlieb made an additional remark that lamented that the ACA has hamstrung many tools which payers have historically used to control costs, resulting in new measures which some find objectionable or which may limit access. As a practitioner, I encounter every day a new loophole or hoop which must be navigated to obtain access for patients to drugs or other doctors or diagnostic testing. While I believe that Dr. Gottlieb is in fact correct - that many of the tools such as charging more for patients with pre-existing conditions- have been eliminated by the ACA, I have no doubt that payers are intelligent enough to discover new ways to control costs. In fact, as stated previously, that innovation both in the private sector and in government managed payment is essential to move the cost needle in a more favorable direction and I encourage it. As those innovations happen however, we must, as a society, take care that there are not unintended consequences disproportionately affecting certain patient populations or certain segments of our society. Many of the items related enumerated above, such as excessive cost sharing for specialty drugs, go too far in that regard and need to be addressed. Again I thank the committee for the opportunity to discuss these critical issues.